

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but no less than two hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse or did not result in bodily injury, to the facility administrator and to other officials in accordance with State law through established procedures for four (Resident #11, Resident #60, Resident #64, and Resident #98) of 10 residents reviewed for abuse. The facility failed to report allegations of resident-to-resident abuse to HHSC when: On [DATE], when no staff was in the dining room, a resident reported to staff, Resident #64, who was blind, allegedly hit Resident #98 on the chin (no physical injuries). On [DATE] when Resident #64, who was blind, propelled his wheelchair forward and ran into Resident #2's wheelchair. Both residents pushed at each other open fist, and Resident #2 received a small skin tear. On [DATE] CNA K witnessed a verbal and physical altercation between Resident #11 and Resident #60, no injuries. These failures could place residents at risk for delayed investigation, intervention, and abuse. Findings included: Resident #64 and Resident #98. Record review of Resident #64's face sheet, dated [DATE], revealed a fifty-one-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included legal blindness (a government classification for severe vision loss), traumatic brain injury (a disruption in normal brain function caused by a bump, blow, jolt to the head, or penetrating head injury) and delusional disorders (a serious mental illness where a person experiences persistent, unshakable false beliefs (delusions) that are not based in reality). Record review of Resident #64's care plan revealed: problem of Resident #64 attempting to find his way in the dining room via using hands to pat surfaces and inadvertently came across female resident in line of path and hit/pat her in face related to blindness and anxiousness behavior of wheeling around facility randomly dated [DATE] and intervention psychiatry to address resident's increased agitation and increased wandering in wheelchair in facility (no specific destination verbalized) dated [DATE], staff to assist to and from location of choice dated [DATE], and staff to monitor resident's attempts to propel self in group setting and re-direct dated [DATE]. problem Resident #64 had limited physical mobility related to blindness of both eyes, LLE contracture (chronic loss of joint mobility in your left leg, caused by the tightening of muscles, tendons, or ligaments) and impaired cognition dated [DATE] and intervention Resident #64 was extensive to total assistance by 1-2 staff for locomotion using wheelchair dated [DATE]. problem Resident #64 had a history of behavior problems (inappropriate touching of other residents, making inappropriate sexual remarks towards others, attempts to grope female staff, history of smearing bodily wastes, history of pulling penis out of brief and urinating on (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor saturating clothing, history of grabbing a male resident's breast. Resident #64 had a history of TBI (damage to the brain caused by an outside physical force) psychosis and history of unsafe behaviors requiring redirection dated [DATE] and intervention intervene as necessary to protect the rights and safety of others, approach/Speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed dated [DATE]. Record review of Resident #64's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 9 indicating moderate cognitive issues. Record review of Resident #98's face sheet, dated [DATE], revealed a forty-two-year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included multiple sclerosis (a chronic, unpredictable autoimmune disease of the central nervous system (brain, spinal cord, and optic nerves), paraplegia (condition characterized by the partial or complete paralysis of the lower half of the body, including both legs and often the lower trunk), and cachexia (a severe, complex metabolic syndrome characterized by extreme unintentional weight loss, including severe muscle and fat wasting). Record review of Resident #98's care plan revealed problem of a potential communication problem related to MS dated [DATE] with intervention be conscious of resident position when in groups, activities, dining room to promote proper communication with others dated [DATE] and a problem of impaired cognitive function or impaired thought processes related MS dated [DATE] and intervention cue, reorient and supervise as needed dated [DATE]. Record review of Resident #98's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 7 indicating severe cognitive issues. Record review of TULIP reflected the facility did not report a resident-to-resident incident that occurred on [DATE] and involved Resident #64 and Resident #98. Record review of facility Incident by Incident Type report dated [DATE] to [DATE] for category of Resident-to-Resident Incidents reflected Resident #64 and Resident #98 were both involved in an incident dated [DATE]. Record review Resident #64's progress notes dated [DATE] by FDON reflected Resident #64 was in hallway propelling self in wheelchair when DON approached. DON asked Resident #64 if he had hit anyone. Resident #64 stated no. DON asked if he remembered having any physical contact with a female. Resident #64 stated no. Resident #64 also stated he was heading to dining room but did not remember being in dining room earlier. Resident #64 was calm and no aggressive movements. No visible reddened areas noted to Resident #64's fingers or hand and skin intact. Record review of facility Resident to Resident Incident Report dated [DATE] reflected Resident #68 was in hallway propelling self in wheelchair when DON approached. FDON asked if Resident #64 had hit anyone. Resident #64 said no. FDON asked if he remembered having any physical contact with a female. Resident #64 said no. Resident #64 also stated he was heading to the dining room but did not remember being in the dining room earlier. Resident #68 said I would never hit a woman, when asked if he had hit a female resident. Resident also states he does not remember hitting anyone. No injuries observed at the time of incident. IDT review - Resident #64 reportedly inadvertently hit peer in face when attempted to pass her in the dining room, feeling his way due to blindness. Resident #64 not to be left alone in group settings. Review of Incident report reflected no name of female resident. Record review of facility Resident to Resident Incident Report dated [DATE] reflected Resident #98 was sitting in her wheelchair in the dining room. Resident #98's peer had informed DON that Resident #64 hit Resident #98 in the face. Resident #98 said, [Resident #64] hit my mouth. Resident #98 denied having any pain and there was redness on face or mouth and no swelling. Resident #98 had a calm posture and denied being afraid. Resident #98 described she was just sitting there and Resident #64 hit her in the face. When Resident #98 was asked for more details (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident number 98 stated Resident # 64 came up behind her using his hands to touch/pat in a searching manner. Resident #98 said he first patted at her arms, then shoulder and then face before passing her. Resident #98 was assessed head to toe with no visible redness or to her extremities or face. Resident #98's skin was intact with no bruising or visible trauma marks. The DON assured Resident #98 he would take care of issue. Record review of Resident #98's progress notes reflected no progress not for a resident-to-resident incident. During an interview on [DATE] at 2:45 PM with Resident #98 she said a while ago she was in the dining room and was hit on the chin by Resident #64. Resident #98 said Resident #64 was an a***** and she did not want to be around him. Resident #98 said it hurt when it happened, she said she said, ow ow. She said she did not have a bruise. Resident #98 said she told a nurse about it when it happened but did not remember the name of the nurse. During an interview on [DATE] at 3:01 PM with Resident #98's RP said she was aware that Resident #98 had been hit on the chin by Resident #64. Resident #98's RP said she visited Resident #98 the day after the incident and did not see a bruise or a mark on Resident #98's chin. Resident #98's RP said Resident #64 was removed from the dining room for a period of time after the incident. The RP said she found out about the incident from Resident #98 and Resident #98 was pretty mad about it. Resident #98's RP said occasionally, the facility would try to place Resident #64 next to Resident #98 and Resident #98 requested that Resident #64 be moved. During an interview on [DATE] at 8:29 AM with FDON he said he remembered an incident in the dining room involving Resident #64 and Resident #98. FDON said he did not witness the incident, but resident (now deceased) reported the incident to him. The FDON said there were no staff in the dining room where the event occurred because they had not begun serving the meal. The FDON said he went to check on Resident #98 to see if she was okay. The FDON said after he and Resident #98 talked he said Resident #98 told him Resident #64 was trying to get by Resident #98 and as he attempted to get by Resident #98, Resident #64 hit Resident #98 in the face. The FDON said Resident #64 did not attack Resident #98. The FDON said Resident #98 received a head-to-toe skin assessment and Resident #98 had no injuries. The FDON said Resident #98 did not say that she was afraid to be around Resident #64. The FDON said interventions were put in place for someone to be with Resident #64 when he was in his wheelchair because he was blind and had a hard time getting around. The FDON said he did not see it as an incident that was reportable because Resident #64 did not actively go after Resident #98 and they did not have an argument. The FDON said Resident #64 hit Resident #98 accidentally due to his vision impairment. The FDON said when he spoke with Resident #64 about it, Resident #64 said he was not aware that he hit anyone. During an interview on [DATE] at 8:30 AM with Resident #12 she said she was in the hallway from the dining room and saw the altercation between Resident #64 and Resident #98. Resident #12 said it was a long time ago and did not know the date. Resident #12 said Resident #64 was mean to Resident #98. Resident #98 told him to stop, and Resident #64 would not stop. Resident #12 said she did not think Resident #64 hurt Resident #98 badly. Resident #12 said Resident #64 was kicking at Resident #98. During an interview on [DATE] at 9:21 AM with the PNP she said Resident #64 was chronically impulsive and delusional. The Psychiatric NP said there was a situation in the dining room a few months ago, she did not remember the date when Resident #64 reached out and accidentally hit someone. She said she was told about it but did not know the other resident involved was Resident #98. The PNP said she did not receive a call that Resident #98 was the person Resident #64 hit. She said she had no note of a call from the facility or any note that she discussed the incident with Resident #98. During an interview on [DATE] at 9:27 AM with the PNP she said she spoke with Resident #98 about the incident when Resident #64 hit her in the face when they were in the dining room. The PNP said she spoke Resident #98 about the incident and Resident #98 said the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	man who hit her was blind and he did hit her, but Resident #98 was mad because Resident #64 did not admit to hitting her. During an interview on [DATE] at 10:48 AM with Resident #64 he said he remembered hitting a male in the dining room but did not remember hitting anyone else. During an interview on [DATE] at 2:59 PM with the Administrator he said he did not report the incident between Resident #64 and Resident #98 to HHSC because it involved a Resident with cognitive impairment, Resident #64, and the incident did not show any intent by Resident #64 to be harmful or aggressive towards Resident #98. The Administrator said Resident #64 was going in the dining room and initially Resident #64 put his hand on Resident #98's chair and in doing so, he caught Resident #98 in the cheek. The Administrator said Resident #98 was not crying or depressed. The Administrator said he looked at the HHSC provider letter and felt that the incident did not meet the requirements to report because the incident did not involve any intent to harm. The Administrator said Resident #64 did not seek out Resident #98 to intentionally harm her and there were no physical or psychological injuries. Resident #2 and Resident #64 Record review of Resident #2's face sheet, dated [DATE], revealed a sixty-eight-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life), alcoholic cirrhosis of liver without ascites (liver is scarred but can still perform its essential daily functions), and cognitive communication deficit (occurs when a person has difficulty communicating because of disruptions in brain functions like thinking, memory, or attention, rather than a physical problem with the vocal cords or a pure language impairment). Record review of Resident #2's care plan revealed problem of potential for a mood and behavior problem and the potential to be physically and verbally aggressive related to bipolar disorder, adjustment insomnia, unspecified psychosis, Dementia, depression, and poor impulse control dated [DATE] with intervention monitor resident for any signs of aggressiveness while in group activities dated [DATE]. Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues. Record review of TULIP reflected the facility did not report a resident-to-resident incident that occurred on [DATE] and involved Resident #2 and Resident #64. Record review of facility Incident by Incident Type report dated [DATE] to [DATE] for category of Resident-to-Resident Incidents reflected Resident #2 and Resident #64 were both involved in an incident dated [DATE]. Record review of Resident #2's progress notes dated [DATE] reflected AD reported Resident #2, and another resident had an issue in main dining room after activity had completed. Per the AD Resident #2 and Resident #64 were on opposite side of dining room from each other. Resident #64 propelled himself into Resident #2's wheelchair. Resident #2's wheelchair was bumped and both residents were moving hands around pushing at wheelchairs to move away from each other and pushing at each other's hands. Resident #2 was observed with a small skin tear to the left finger. Record review of facility Resident to Resident Incident Report dated [DATE] reflected per AD Resident #64 was in the main dining room listening to music in his wheelchair. Resident #64 was legally blind and ended up attempting to wheel himself into another location. Resident #64 accidentally bumped his wheelchair into Resident #2's wheelchair and the two began pushing each other away open hands. Resident #64 unable to give description. No injuries observed at this time. Record review of facility Resident to Resident Incident Report dated [DATE] reflected AD reported Resident #2, and another resident had an issue in main dining room after activity had completed. Per AD residents were on opposite side of dining room from each other, Resident #64 who was blind, propelled self into Resident #2, witnessed by AD. Resident #2's wheelchair was bumped, both residents were moving hands around pushing at wheelchairs to move away from each other and pushing at each other's hands. Resident #2 was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed with small skin tear to left ring finger. Resident #2 unable to give descriptions. Statement by AD stated at approximately 11:00 AM on [DATE] both Resident #64 and Resident #2 were attending activities in the dining room. Resident #2 was listening to music and Resident #64 was across the room where residents were conducting table games. The AD said she monitored the residents during the activity, and there were no incidents between Resident #2 and Resident #64. The AD stated as she was returning residents to their rooms, the AD returned to see Resident #64 had inadvertently wheeled his chair to the side of Resident #2's chair. Resident #2 was in the same spot the AD left him and Resident #64 had navigated across the room and bumped into Resident #2's chair. The AD said neither resident was hitting the other and their fists were not closed. The AD said they were pushing away from each other's position. The AD said both residents were immediately separated and understanding Resident #64 was blind, the AD said she redirected him back to his room. The AD said she notified the ADON and administrator. During an interview on [DATE] at 8:46 AM with the FDON he said both Resident #2 and Resident #64 could be aggressive. The FDON said the incident between Resident #2 and Resident #64 was not reported because there was a staff member in the dining room with Resident #2 and Resident #64. The FDON said the residents were kind of pushing at each other and not punching each other. The FDON said the residents were pushing back to each other's wheelchair with no deliberate aggression. The FDON said if the residents do not have deliberate aggression towards each other and no deliberate injury he did not report this kind of incident to HHSC. During an interview on [DATE] at 10:42 AM with Resident #2 when asked if he was hit by another resident at the facility, Resident #2 said maybe he got hit but he did not know. During an interview on [DATE] at 11:06 AM with the AD she said Resident #2 and Resident #64 were in the dining room and an activity was breaking up and the AD was assisting residents to return to their rooms. Resident #2 and Resident #64 were separated from each other. The AD said when she returned to the dining room Resident #64, who was blind, bumped into Resident #2 and they were trying to get off of each other. The AD said Resident #2 was telling Resident #64 to get back and Resident #64 was confused and he kept pushing back. The AD said Resident #2 was aggravated and Resident #64 was upset. The AD said she knew of no injuries. She said she was trained in abuse, neglect, and exploitation and said any unwanted touching would be resident to resident altercation and should be reported to the Administrator. She said the Administrator was the abuse and neglect coordinator. The AD said it would be up to the Administrator to determine if it would be reported to the State of Texas. During an interview on [DATE] at 2:59 PM with the Administrator he said he met with the AD who depicted the incident between Resident #2 and Resident #64 as a situation where the residents were pushing their wheelchairs away from each other, did not have closed fists and were not going after each other so he did not report it to HHSC. Resident #11 and Resident #60 Record review of Resident #11's face sheet, dated [DATE], revealed seventy-nine year old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life), adjustment disorder (an intense emotional or behavioral reaction to a major life stressor, like a job loss or divorce), and hemiplegia and hemiparesis (Hemiplegia refers to total or near-total paralysis, while hemiparesis refers to milder, partial muscle weakness). Record review of Resident #11's care plan revealed problem of Resident #11 had a communication problem related to aphasia (a neurological disorder caused by brain damage that impairs your ability to speak, understand, read, and write). Resident #11 was without speech. Resident #11 was usually understood and usually understood. Able to nod head, use hand gestures and use written communication dated [DATE] with intervention anticipate and meet needs dated [DATE] and Resident #11 had potential to be physically aggressive (HITTING) related to anger dated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] with intervention and intervention analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document dated [DATE].Record review of Resident #11's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 12 indicating moderate cognitive issues.Record review of Resident #60's face sheet, dated [DATE], revealed a seventy-nine-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life), sequelae of cerebral infarction (long-term or permanent neurological, physical, and cognitive deficits that persist after an ischemic stroke), and dysarthria and anarthria (related motor speech disorders caused by brain or nerve damage that impairs the muscles controlling speech). Record review of Resident #60's care plan revealed problem of Resident #60 had potential to be physically aggressive by attempting to hit staff or other residents related to anger, dementia, history of harm to others, poor impulse control dated [DATE] with intervention separate residents dated [DATE].Record review of Resident #60's MDS (clinical assessment to determine resident's strength and needs) dated [DATE] Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 13 indicating no cognitive issues.Record review of TULIP reflected that the facility did not report a resident-to-resident incident that occurred on [DATE] and involved Resident #11 and Resident #60.Record review of facility Resident to Resident Incident Report dated [DATE] reflected CNA K alerted LVN I that Resident #11 was involved in a witnessed incident with another resident. Resident #11 was in the hallway asking to go to bed. The other resident became upset and propelled out of his room in his wheelchair yelling at Resident #11. Resident #11 approached the other resident and then the other resident used his foot to come into physical contact with Resident #11's lower extremity with minimal force due to his weakness. Resident #11 reciprocated in the same manner. This prompted the other resident to stand up and utilize his hand to come into physical contact using minimal force with Resident number 11's left shoulder. Due to a speech deficit, Resident #11 was unable to give a good description, but answered but answered LVN I's questions with yes and no answers. CNA I immediately intervened between both residents preventing any further incident and ensuring the safety of both residents. She then proceeded to separate the residents and propelled the other resident into his room and then propelled Resident #11 into his room. Once CNA K separated residents and ensured their safety she promptly approached LVN I to report incident. LVN I immediately went to perform physical assessment and skin check of each resident. Resident #11 denied any pain or discomfort related to the incident. No apparent injuries observed. No signs and symptoms of emotional distress distress observed. Administrator, DON, NP, and RP notified.During an interview on [DATE] at 3:41 PM with Resident #60 he said he had an issue with Resident #11, but now they are okay. During an interview and observation on [DATE] at 3:48 PM with Resident #11, when asked if he had an altercation with another Resident he motioned with his hands and waved for surveyor to follow him. Resident #11 rolled his wheelchair and pointed to Resident #60. During an interview by phone on [DATE] at 2:00 PM with CNA K she said Resident #60 was outside of his room and Resident #11 asked her to help him get to bed. CNA K said Resident #60 told Resident #11, don't talk to my lady and was rude to Resident #11. CNA K said Resident #11 began kicking at Resident #60 and Resident #60 called Resident #11 a mother***** and kicked back at Resident #11. CNA K said Resident #60 swung his fist at Resident #11 and hit him. CNA K said she got in the middle of the residents and separated them. CNA K said neither resident was injured and there were no hard puches by either resident. CNA K said she notified LVN I and the residents were both assessed. CNA K said she was trained in abuse, neglect, and exploitation. CNA K said the exchanged between the residents was a resident to resident (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	altercation. CNA K said there had been no past resident to resident issues involving Resident #11 but there had been resident to resident issues in the past involving Resident #60. During an interview by phone on [DATE] at 4:01 PM with LVN I said she worked at facility PRN and was at the nurses station when CNA K said Resident #11 and Resident #60 had a physical altercation. LVN I said CNA K was in the hallway with Resident #11 and asked CNA K for a shower. Resident #60 was in his room and came out to the hallway kicking towards Resident #11 and Resident #11 was kicking towards Resident #60. LVN I said CNA K separated them and took each resident to their room. LVN I said she assessed both residents and neither resident had complaints of pain and their skin assessment showed no marks. LVN I said neither resident had emotional distress. LVN I said she monitored both residents through the remainder of her shift. LVN I said there was minimal contact and interaction during the incident. LVN I said she filled out an incident report because it was a resident-to-resident altercation. LVN I said she received abuse, neglect, and exploitation training at the facility and the Administrator was the abuse and neglect coordinator. LVN I said it was not her call to decide when to report incidents between residents to the state. She said it was a minimal incident with no injury and no emotional harm. During an interview on [DATE] at 2:59 PM with the Administrator he said Resident #60 saw Resident #11 in the hallway and started yelling at Resident #11. The Administrator said they were kicking at each other but there was no harm and felt like they laughed it off. The Administrator said the residents were too weak to do any physical harm to each other. The Administrator said both residents were redirected back to their rooms. The Administrator said he would characterize the incident between Resident #11 and Resident #60 as a Resident-to-Resident altercation but did not feel like it rose to the level of abuse and needed to be reported. The Administrator said if there was an allegation where he felt one resident threatened another resident, for example threatening to go into another resident's room and beat them up, he would consider that abuse. He said there was no clear-cut abuse between Resident #11 and Resident #60. Review of the facility's Abuse, Neglect and Exploitation Policy dated [DATE] reflected that the facility will have written procedures to assist staff in identifying the different types of abuse -mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse-and certain resident to resident altercations. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in 1 of 1 kitchen. The facility failed to ensure meals were served in accordance with facility dining hours and endure residents were not brought into the dining room to wait for an extended period of time for their food to be served. This failure could place residents at risk of cold food, dehydration, weight loss, and quality of life. Findings included:Record review of Resident #86's face sheet, dated 06/16/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (an ongoing, progressive lung condition that obstructs airflow, primarily caused by smoking or long-term exposure to irritants), type 2 diabetes mellitus with diabetic chronic kidney disease (occurs when prolonged high blood sugar damages the kidney's filtering units), and abnormalities of gait and mobility (any irregular, uncoordinated, or painful walking pattern). Record review of Resident #86's care plan revealed: problem Resident #86 had a potential fluid deficit related to poor intake dated 04/01/2026 with intervention educate Resident #86 and his family and caregivers on importance of fluid intake dated 04/01/2026. Record review of Resident #86's MDS (clinical assessment to determine resident's strength and needs) dated 12/19/2025 Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 11 indicating moderate cognitive issues. Record review of Resident #56's face sheet, dated 06/16/2026, revealed an [AGE] year old male who was admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease ((an ongoing, progressive lung condition that obstructs airflow, primarily caused by smoking or long-term exposure to irritants), personal history of malignant neoplasm of prostate (indicates that a patient has previously been diagnosed with and treated for prostate cancer, and is currently in remission without active disease), and monoclonal gammopathy (a blood disorder where your plasma cells produce an abnormal protein called an M-protein or paraprotein). Record review of Resident #56's care plan revealed problem: Resident #86 had a problem of potential nutritional problem related to diet restriction of no added salt dated 05/11/2026 with an intervention of provide, serve diet as ordered and monitor intake and record every meal dated 05/11/2026. Record review of Resident #56's MDS (clinical assessment to determine resident's strength and needs) dated 04/23/2026 Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 9 indicating moderate cognitive issues. Record review of Resident #19's face sheet, dated 06/16/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitting on 05/03/2023. His diagnoses included cerebral infarction (occurs when a blood vessel in the brain is blocked or significantly narrowed), anxiety disorder (persistent, excessive fear or worry in everyday situations that are disproportionate to the actual threat), and spontaneous ecchymoses (unexplained bruising or blood pooling under the skin larger than 1 centimeter). Record review of Resident #19's care plan revealed problem: Resident #19 had a problem of Resident #2 experienced a 7.3 percent weight gain in 1 month dated 08/16/2025 with intervention monitor and record food intake at each meal dated 08/16/2025. Record review of Resident #19's MDS (clinical assessment to determine resident's strength and needs) dated 02/09/2026 Nursing Home Comprehensive Section C - Cognitive Patterns revealed a score of 7 indicating severe cognitive issues.Record review of the facility dining hours reflected:Breakfast - 7:15 AM, Lunch - 11:30 AM, Dinner - 5:15 PM Observation on 06/14/2026 of the first lunch trays coming out of kitchen and being placed on the serving cart at 12:53 PM and 300 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hall trays beginning to be passed at 1:15 PM.Observation on 06/14/2026 at 1:00pm revealed lunch tray beginning to be served to the residents seated in the dining room. During an interview on 06/14/2026 at 1:00 PM with Resident #86 he said it bothered him that lunch was served late because he wanted food to be served punctually. Resident #86 said lunch had been served late for about a month. Observation on 06/15/2026 at 12:47 PM revealed lunch trays being checked to confirm that the resident meal tickets matched the food that was on the resident tray. No trays had been passed to any residents on any hallway at that time. During an interview on 06/15/2026 at 12:47 PM with LVN I she said she could not answer why lunch was being served late. LVN I said she did not know what was going on inside the kitchen.During an interview on 06/15/2026 at 1:15 PM with Resident #2 she said it bothered her when lunch was late because they carted her into the dining room for no reason and she just sat and waited for no reason. During an interview on 06/15/2026 at 2:00 PM with Resident #56 he said lunch was one and a half hours late and that bothered him because he was a firefighter for 29 years and things should be kept punctual and have some kind of order. During an interview on 06/16/2026 at 12:48 PM the RD said he came twice a week to the facility. The RD said that meals should be served as close to the time that it was posted to serve meals as was possible. The RD said it was a combination of all staff who were responsible for getting meals on time to the residents. The RD said it can affect residents if meals were served late because mealtimes usually cause peaks in appetite and the facility wants residents to maintain weights and appetite.During an interview on 06/16/2026 at 12:59 PM with the DM he said he had been working at the facility for almost 3 months. He said meals should go out as soon as possible according to schedule. He said lunch was scheduled to begin at 11:15 AM so lunch should be no later than 11:35 AM ish. The DM said all the kitchen staff, the CNAs and the nurses were responsible for getting the residents their meals on time. The DM said that if meals are late, snacks are late and medications are late. During an interview on 06/16/2026 at 1:06 PM with the Administrator he said his expectation was scheduled meals should be served beginning on the 100-hallway at the posted mealtimes. The Administrator said DM was responsible for making sure meals were served on time. The Administrator said he wants meals served on time because he did not want residents to get hungry and late meal affected the day and interfere with resident plans. No facility policy with the exception of the posted mealtimes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for one of the facility reviewed for the pest control program. The facility failed to keep flies out of resident rooms, the facility kitchen, and the facility common areas. This failure placed residents at risk of infection, feelings of fear, anxiety, disgust, helplessness, shame, and a diminished quality of life. Findings included: Review of Resident #80's admission record, dated 06/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's Disease (a condition that slowly damages the brain and affects thinking, memory, and the ability to do everyday tasks), contractures (when the soft tissues around a joint tighten, shorten, and lost their ability to stretch), and lack of coordination. Review of Resident #80's comprehensive MDS, dated [DATE], reflected a BIMS score was not conducted due to resident was rarely/never understood. Review of Resident #72's admission record, dated 06/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and last readmitted on [DATE]. Her diagnoses included unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs), and chronic diastolic heart failure (when the heart becomes stiff and cannot relax properly making it harder to fill with blood and supply the body with blood). Review of Resident #72's quarterly MDS, dated [DATE], reflected a BIMS score of 15 which indicated no cognitive impairment. Review of Resident #84's admission record, dated 06/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included unspecified asthma (chronic disease in which the bronchial airways in the lungs become narrowed and swollen and make it difficult to breathe), anxiety disorder (intense and excessive worry and fear), and chronic kidney disease (a gradual loss of kidney function over time). Review of Resident #84's quarterly MDS, dated [DATE], reflected a BIMS score of 11 which indicated moderate cognitive impairment. During an observation on 06/14/2026 at 09:17 AM, a fly was observed in the kitchen's dry goods storage area. During an observation on 06/14/2026 at 12:13 PM, four flies were observed on Resident #80's legs in the assisted dining room. Resident #80 appeared to move her legs anytime a fly moved on her bare skin. Resident #80 could not complete an interview. During an observation of dining services on 06/14/2026 at 12:49 PM a fly was observed on a dining room table and another dining room table there were two flies on it. During an observation and interview on 06/15/2026 at 09:10 AM, Resident #72 was observed with one fly flying around her head and randomly landing on objects on Resident #72's over the bed table in her room. Resident #72 stated the flies really bothered her and made her feel awful. During an interview and observation on 06/15/2026 at 10:30 AM, a fly was observed landing on the end of the straw that was in Resident #84's hydration cup in her room. Resident #84 stated the flies bother her because they bite. She stated the flies could land on your face, bite you and lay eggs or worms in the skin when they bite you. During an interview on 06/15/26 at 11:56 AM with CNA L stated flies were on the faces of the residents who were assisted with feeding in the dining room. She stated the residents did not have the capability to swat the flies away. CNA L stated it was gross that the flies were landing on the residents. During an interview on 06/16/2026 at 09:50 AM, the DON stated she was unsure what the policy for pest control was, but she knew the exterminator came into the facility to spray on an unknown frequency. The DON stated she had not received any complaints or concerns related to pest control. She stated she educated the residents during her rounds to close any open snacks to prevent (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any pests. The DON stated she asked residents in the dining room if they had any problems with pests and no concerns were revealed to her. She stated if a resident or staff were to express concerns with pests, she would notify the ADM and the MAIN. The DON stated all staff monitored for pests when they performed their rounds. She stated flies in the facility could cause discomfort or annoyance to the residents and it could potentially attract more pests. The DON stated the flies were in the facility due to people going in and out of the smoking door in the dining room. During an interview on 06/16/2026 at 11:27 AM, the ADM stated the policy for pest control was to have a contract in place with a pest control service, ensure the pest control service was coming as scheduled and to monitor for pests between pest control service visits. He stated staff typically would call him or the MAIN with issues that needed to be addressed. He stated cleanliness was a big part of pest control too. The ADM stated the pest control service would also come to the facility outside of scheduled times to address any issues that were reported. The ADM stated the pest control service visited the facility at a minimum once a month, but typically it was two times a month because they would call the pest control service out to address needs. He stated they had a planned visit for Friday, 6/19/2026. The ADM stated he had not received any complaints related to pests lately. He stated if he were to receive a complaint about pest control, then he would go to where the pest was located to get rid of what is attracting them, then he would notify pest control to come to the facility and perform a treatment. The ADM stated pests, including flies, could contribute to infection control and sanitation matters. He stated the primary staff who were responsible for pest control monitoring were the housekeeping and maintenance staff but ultimately it was all staff who were responsible for monitoring for potential pest issues in the facility. The ADM stated pest control was monitored during daily rounds and environmental rounds. The ADM stated there were flies in the facility due to several possible factors including: the heat, the food smells, the cooler air coming from inside the facility, when deliveries come and the doors are open, and the frequency of the in and out activity that happens around the activities planned. During an interview on 06/16/2026 at 12:26 PM, the ICP stated the policy for pest control was to have routine pest control visits, log any sightings of pests in the binder, and to have them make additional visits anytime there was a concern raised. She stated she was unsure how often pest control made their routine visits. The ICP stated she had not received any complaints related to pests or flies. She stated if she were to receive a complaint related to pest control, she would log it in the binder and notify the MAIN and the ADM. She stated if the issue could be addressed immediately then she would address the issue. The ICP stated all staff were responsible for monitoring for pests within the facility when they perform their rounds. The ICP stated having flies in the facility could make residents feel uncomfortable, give them anxiety, or could even possibly spread disease. She stated the heat was drawing the flies in anytime a door was opened they would come in. During an interview on 06/16/2026 at 12:40 PM, the MAIN stated the pest control company came out once a month routinely to perform a full service for pest control. He stated if there were concerns, he could contact the pest control company, and they would be on site within 24 hours to deal with the concern. The MAIN stated he had a few concerns raised to him about scorpions. He stated the pest control company missed the scheduled visit on 06/15/2026 due to the rain, but they were scheduled to come on 06/19/2026. He stated all staff were responsible for monitoring for pests in the facility when performing their rounds. He stated he monitored for pests when doing his maintenance and his rounds. The MAIN stated the residents may be negatively impacted because no one wants pests in their home and this is their home. The MAIN stated there were so many flies in the building because the heat and wet weather drew them in. He stated the facility had reported the flies to the pest control company for treatment and the facility had air (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	curtains (a strong flow of air over a doorway when the door is opened to discourage pests) on the dining room doors but the flies were still able to get inside the facility. Review of facility policy titled General Kitchen Sanitation, dated 10/01/2018 reflected Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. Procedure: 13. Have a professional pest-control program in place. Record review of Pest Control Invoices from 01/31/2026 to 06/01/2026 revealed the facility had insect light traps outside the building. The invoices also revealed the facility was not being treated inside the building for flies.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 17 residents (Resident #15) reviewed for resident rights. The facility failed to ensure Resident #15 was treated with dignity and did not have his name written big on the back of his shirt visible to everyone. This failure could place residents at risk of feeling embarrassed or cause emotional distress. Findings Included: Record review of Resident #15's face sheet, dated 06/16/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included anemia (not enough healthy red blood cells), muscle wasting, unsteadiness on feet, type 2 diabetes mellitus with diabetic kidney disease (kidney damage due to diabetes), cognitive communication deficit (problems with communication), hyperlipidemia (high cholesterol), heart disease, and hypertension (high blood pressure). Record review of Resident #15's quarterly MDS assessment dated [DATE] revealed Resident #15 had a BIMS score of 10, which indicated moderate impairment. Observation in the dining room on 06/14/2026 at 12:53p.m., revealed that Resident #15's name was written big on the back of his shirt visible to everyone. During an interview with the DON on 06/16/2026 at 9:30a.m., revealed she had been trained on resident rights. She said the policy for providing the resident with dignity was providing privacy, encourage independence while also helping to keep the residents safe, treat with respect, tell them what you are going to do before treatments. She said everyone in the building was responsible for providing the residents with dignity. She said she was not sure who put the names on the resident's clothing. She said the name had always been the inner tag on the clothing. She said she had seen some hats with some names on the outside, but she did not know who did it. She said it depended on the resident and their preference on how their name on the outside of their shirt would make them feel. She said she would have to look into who monitored to ensure the residents were treated with dignity. She said she did not know why Resident #15's name was written on the outside of his shirt. During an interview with the ADM on 06/16/2026 at 10:57a.m., revealed he had been trained on resident rights. He said the policy was to inform the resident and families of their rights. He said the facility educated the staff to continually be raising awareness of the residents rights. He said management did routine rounds, and if a breach was identified during those rounds, then management was able to address the concern with education. He said there was also a grievance process where residents could make issues known and management could address those issues. He said it was a collective effort from everyone on the team to provide the residents with dignity. He said staff give the family a marker and the family would put the name on the residents clothing. He said some residents might not care about their name being on the outside of their shirt. He added if a resident did care he said the resident would let management know. He said staff knew better than putting the residents name on the outside. He said if he saw it he would likely ask about it whether it was the resident's preference or not when asked who monitored to ensure residents were treated with dignity. He said everyone had to have awareness to monitor and if a resident was uncomfortable or if the resident brought it up it should be addressed. He said he did not know why Resident #15's name was written on the outside of his shirt. He said he could make a phone call and ask around to find out why his name was on the outside of his shirt. During an interview with the ES on 06/16/2026 at 1:18p.m., she said she had been trained on resident rights. She said the policy for dignity was to make sure the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident felt comfortable and cared for. She said if staff had any issues regarding the residents they were to talk to the ADM. She said staff did put the residents name on the clothing, but she tried to encourage families to do it when the resident was first admitted or when they bring stuff in. The names should go inside the shirt on the back (gestures to upper collar of shirt near label). Same with the pants. It goes inside the pants on the back up at the top. She said if it was her and her name was written on the outside of her shirt big for everyone to see she would not like it. She said she did not know who monitored to ensure residents were treated with dignity. She also said she was not aware Resident #15's name was written on the outside of his shirt, During an interview with MA G on 06/16/2026 at 1:41p.m., she said she had been trained on resident rights. She said the policy for dignity was to provide the resident with privacy, not to talk about resident where other people could hear. She said all staff were responsible for providing the resident with dignity. She said sometimes families, or staff put the name of the resident on their clothing. She said the residents name was supposed to go inside the resident's shirt or inside the pants. She said she thought putting the resident's name on the outside of their shirt was a dignity issue and someone just might not like it. She said all staff monitored to ensure the residents were treated with dignity. She said she did not know how it was monitored. She also said she did not know why Resident #15's name was written on the outside of his shirt. During an interview with Resident #15 on 06/14/2026 at 2:02p.m., he said that staff put his name on the back of his shirt. He said staff put his name on the back of his shirt because his clothes were coming up missing. He said he would prefer his name on the inside of his shirt. He said his name on the outside did not make him feel good. He said his name on the back of his shirt where everyone could see was tacky. During an interview with LVN H on 06/16/2026 at 2:17p.m., she said she had been trained on resident rights. She said the policy for dignity was to provide the resident choices in clothing, providing privacy and participating in their treatment. She said all staff were responsible for providing the resident with dignity. She said families would put the name on the residents clothing and if not the staff would put their name on the clothing. She said the residents name was supposed to go inside the resident's shirts. She said how a resident felt about the resident's name was on the outside of his shirt depending on the resident. She said some residents might like it some might not like it. She said it was important to get the residents preference. She said everyone who interacted with the resident could monitor to ensure the resident was treated with respect. She said everyone could monitor through observations. She also said she did not know why Resident #15's name was written on the outside of his shirt. Record review of Promoting/Maintaining Resident Dignity Policy dated 01/13/2023 revealed It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for three of eight residents. (Resident #9 Resident #30, and Resident #40) reviewed for reasonable accommodation of needs. 1. The facility failed to ensure the call light system in Resident #9's room was in a position accessible to the resident on 06/14/2026 and 06/15/2026.2. The facility failed to ensure the call light system in Resident #30's room was in a position accessible to the resident on 06/14/2026.3. The facility failed to ensure the call light system in Resident #40's room was in a position accessible to the resident on 06/14/2026. These failures could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. 1. Record review of Resident #9's admission Record, dated 06/15/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #9's Diagnosis Report, dated 06/15/2026, reflected diagnoses which included schizophrenia (a chronic mental illness characterized by psychosis, disruptions in thought process), Bipolar (a mental health condition characterized by severe, dramatic shifts in a person's mood, energy, and activity levels.) hypertension (high blood pressure), type2 diabetes mellitus (body does not produce enough insulin),and anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life).Record review of Resident #9's Annual MDS, dated [DATE], reflected Resident #9 had a BIMS score of 13, indicating mild cognitively impaired. Resident #9 required supervision for toileting and transfers in and out of bed.Record review of Resident #9's, undated, Care Plan, undated and accessed on 06/15/2026, reflected Resident #9 was at low risk for falls and poor safety awareness initiated 04/22/2025 and revised 04/15/2026. An intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare- free light, a working and reachable call light.During an observation on 06/14/2026 at 9:10 AM., Resident #9 was observed sitting on her recliner. Her call light cord was observed on the floor under the bed.Observation and interview on 06/15/2026 at 8:00 AM., Resident #9, was observed sitting on the edge of her bed. Her call light was observed on the floor under her bed. When asked her how she calls for assistance if she needs it she said she waits until they come in. 2. Record review of Resident #30's admission Record, dated 06/15/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #30's Diagnosis Report, dated 06/15/2026, reflected diagnoses which included hypertensive heart disease (high blood pressure), unspecified dementia (group of symptoms that affect memory, thinking, and other cognitive functions, significantly impacting daily life), Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment, history of falling (experienced one or more unintended falls in the recent past), and anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life).Record review of Resident #30's Annual MDS, dated [DATE], reflected Resident #30 had a BIMS score of 12, which indicated mild cognitively impaired. Resident #30 requires supervision for bed mobility and transfers. Resident use a wheelchair.Record review of Resident #30's, undated, Care Plan, accessed on 06/15/2026, reflected Resident #30 was at high risk for falls (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and, poor safety awareness, initiated 04/25/2024 and revised on 04/23/2025. An intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare- free light, a working and reachable call light.During observations on 06/14/2026 at 9:12 AM and 11:15 AM, Resident #30, was observed lying in her bed asleep. Resident #30's call light was inside a laundry basket with stuffed animals and clothing on top of it. 3. Record review of Resident #40's admission Record, dated 06/15/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #40's Diagnosis Report, dated 06/15/2026 reflected diagnoses which included Alzheimer's disease) a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment, type 2 diabetes mellitus(body does not produce enough insulin), muscle wasting and atrophy (loss of muscle tissue and strength), unsteadiness on feet(feeling of wobbliness, or imbalance on feet), and history of falling(experienced one or more unintended falls in the recent past).Record review of Resident #40's Annual MDS, dated [DATE], reflected Resident #40 had a BIMS score of 15, which indicated she was cognitively intact. Resident #40 was supervision assist with her self-care needs and mobility needs.Record review of Resident #40's, undated, Care Plan accessed on 06/15/2026, reflected Resident #40 was at risk for falls and impaired mobility initiated 12/06/2024 and revision on 03/19/2026. An intervention included Be sure the resident's all light is within reach and encourage the resident to use if tor assistance as needed. During an observation on 06/14/2026 at 09:15 AM. Resident #40 was observed lying in her bed sleeping with her call light laying on the far side of the bedside table away from the resident. During an interview on 06/16/2026 at 8:15 AM, CNA D said when she puts a resident to bed, she makes sure the call light was within reach. She said if it was not within reach a resident cannot reach it and was unable to call for help. During an interview on 06/16/2026 at 8:30 AM, the DON stated her expectation was when residents were in bed, call lights should be on the bed where the resident could reach it. She stated the resident might miss an opportunity to be able to call for the nurse if the call light was not within reach. She stated all staff had been in service on call light placement. The DON stated her expectation was call lights were always within reach of the resident when they were in bed.During an interview on 03/05/2026 at 9:15 AM with the ADM, he stated he expected all staff to place the call light on the bed where it could be reached. The ADM stated the department heads have a daily morning round where they check resident rooms to make sure the call lights are in place. He said staff should be rounded every 2 hours and should automatically be checking on all call lights.Record review of the facility's policy, Call Lights: Accessibility and Timely Response, Date Implemented 10/13/2022. Policy: The purpose of this policy is to ensure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance.Policy Explanation and Compliance Guidelines:5. Staff will ensure the call light is within reach of residents and secured, as needed.6. The Call system will be accessible to residents while in their bed or other sleeping accommodations within the residents' room.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 14 residents (Resident #36, and Resident #68) reviewed for accuracy of assessments. The facility failed to ensure Resident #36's annual MDS, dated [DATE], accurately reflected her smoking status. The facility failed to ensure Resident #68's annual MDS, dated [DATE], accurately reflected his smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment for smoking status. Findings include: 1. Record review of Resident #36's face sheet, dated 06/16/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #36 had diagnoses which included cerebral palsy (a group of conditions that affect movement and posture), muscle wasting, unsteadiness on feet, cognitive communication deficit (problems with communication), heart failure, pain, muscle weakness, hypertension (high blood pressure), history of falling and lymphedema (localized swelling). Record review of Resident #36's annual MDS, dated [DATE], revealed Resident #36 had a BIMS score of 15, which indicated intact cognitive response. The MDS also revealed that current tobacco use was marked as no. Record review of Resident #36's care plan, dated 05/18/2026, did not reflect Resident #36's smoking status. Record review of Resident #36's Smoking Assessment on 06/15/2026, revealed Resident #15 did not have a smoking assessment completed. During an interview with Resident #36 on 06/15/2026 at 9:26a.m., he said that he was a smokeless tobacco user. He said that he had a can of snuff (finely ground smokeless tobacco) in his room. He said he used the tobacco once a day. He added that staff knew he had the snuff. Observation of Resident #36 on 06/15/2026 at 9:18a.m., revealed Resident #36 had a can of wintergreen snuff in his bedside table. 2. Record review of Resident #68's face sheet, dated 06/16/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #68 had diagnoses which included dementia (memory, thinking, difficulty), muscle wasting, unsteadiness on feet, cognitive communication deficit (problems with communication), kidney failure, hypertension (high blood pressure), heart failure, and major depressive disorder (mental health disorder characterized by persistent depressed mood). Record review of Resident #68's annual MDS, dated [DATE], revealed Resident #68 had a BIMS score of 11, which indicated moderate impairment. The MDS also revealed current tobacco use was marked as no. Record review of Resident #68's care plan, dated 04/02/2026, did not reflect Resident #68's smoking status. Record review of Resident #68's Smoking Assessment, on 06/15/2026, revealed Resident #68 did not have a smoking assessment completed. During an interview with Resident #68 on 06/16/2026 at 9:49a.m., he said that he was a smokeless tobacco user. He said that he uses the smokeless tobacco pouches so that he did not make a mess. He said he spits in a cup. He said no one knew he dipped and that he kept his snuff in his pocket. He said the snuff helped with his anxiety and helped keep him calm. He said he did not want the facility to take it away from him because he needed it for his nerves. During an interview with the RN B on 06/16/2026 at 10:00a.m., she said she was the MDS Coordinator. She said she was trained on the MDS. She said certain sections were done by different departments. She said she was responsible for completing the MDS after all the departments completed their section. She said information that was on the MDS were assessments, demographics, BIMS, diet, and discharge goals. She said the MDS should be completed when there was a significant change, annually, and quarterly. She said she had fourteen days from admission to complete the MDS. She said the resident's tobacco use would be put on the admission, annual and significant change MDS. She said if the resident's smoking status was not coded correctly it could affect the residents (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preference and comfort. She said the social worker would inform her when a resident was a smoker. She said the corporate MDS person monitored to ensure the MDS was completed correctly. She said the corporate MDS person would do regular reviews of the MDS. She said Resident #36 and Resident #68's smoking status could have been missed, or the resident may not have reported it to the facility on admission. During an interview with the SW on 06/16/2026 at 10:21a.m., she said she had been trained on the MDS. She said certain sections were done by different departments. She said the MDSN was responsible for completing the MDS after all the departments completed their section. She said information that was on the MDS were BIMS, behaviors, discharge planning, and diet. She said the MDS should be completed when there was a significant change, quarterly, discharge to the hospital, and when the resident returns from the hospital. She said she had until the assessment reference date, which was determined when the MDS coordinator opened the MDS. She said she did not know if the residents smoking status went on the MDS. She said if the resident's smoking status was not coded correctly it could affect the residents burning themselves, have issues with their tongue and gums, and their sanitation. She said the nurse would inform her when a resident was a smoker after the resident was admitted . She said the MDSN monitored to ensure the MDS was completed correctly. She said the MDSN would do regular reviews of the MDS. She said she did not know why Resident #36 and Resident #68's smoking status was not on their MDS. During an interview with the ADM on 06/16/2026 at 10:40a.m., he said he had been trained on the MDS. He said the policy for MDS was that MDS should be done on admission, change of condition and every quarter. He said the MDSN was responsible for completing the MDS accurately. He said the MDS had the resident's smoking status on it. He said if the resident's smoking status was on the MDS it would help the staff to better serve the resident's needs. He said the MDSN, and the DON monitored to ensure the MDS was correct. He said the MDSN and the DON had a consultant that came in once a month and reviewed the MDS for accuracy. He said it appeared a family member brought Resident #36 and Resident #68 smokeless tobacco and the MDSN was not made aware of it. Record review of the Smoking Residents list provided on 06/14/2026 revealed Resident #36, and Resident #68 were not on the smoking list. Record review of Smoking Residents Policy dated 10/24/2026 revealed It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and nonsmoking residents. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. Residents who smoke will be further assessed, using the Smoking Safety Screen UDA, to determine safety with smoking. Record review of the Assessment Frequency/Timeliness Policy dated 10/24/2022 revealed The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. A significant correction assessment will be completed no later than the 14th calendar day after determination that a significant error in a prior OBRA assessment occurred.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 14 residents (Resident #36 and Resident #68) whose comprehensive person-centered care plans were reviewed. 1.The facility failed to include Resident #36 use of smokeless tobacco in his care plan.2.The facility failed to include Resident #68 use of smokeless tobacco in his care plan. This could affect residents by failing to ensure residents received appropriate care for their health conditions.1.Record review of Resident #36's face sheet dated 06/14/2026, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: cerebral palsy (a condition caused from damage or abnormal development to a part of the brain which is responsible for muscle movement and leads to movement disorders and may result in developmental delays and sensory impairments), muscle wasting and atrophy (loss of muscle tissue and strength), and hypertensive heart disease (high blood pressure).Record review of Resident #36's MDS dated [DATE] revealed a BIMS score of 15, indicating no cognitive impairment.Record review of Resident #36's comprehensive care plan undated and accessed on 06/14/2026, revealed no use of tobacco products, goals or interventions for tobacco products listed on the care plan. 2.Record review of Resident #68's face sheet dated 06/15/2026, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: unspecified dementia, mild, with mood disturbance(group of symptoms that affect memory, thinking, and other cognitive functions), type 2 diabetes mellitus without complications(body does not produce enough insulin), muscle wasting and atrophy (refers to the loss of body mass and strength). Record review of Resident #68's MDS dated [DATE] revealed a BIMS of 06 indicating moderately impaired cognition. Record review of Resident #68's comprehensive care plan undated and accessed 06/15/2026 revealed no use of tobacco products, goals or interventions for tobacco products listed on the care plan. During an interview on 06/16/2026 at 9:00 AM, RN B and LVN A stated care plans were interdisciplinary. Surveyor asked if a resident using smokeless tobacco should be included in the care plan. RN B and LVN A both replied yes, it should have been included. During an interview on 06/16/2026 at 8:30 AM, the DON said the Resident#36 and #68 should have been assessed upon admission for tobacco use. The DON said they did an audit the day before and that was how they found out Resident # 36 and Resident #68 used smokeless tobacco.During an interview on 06/16/2026 at 9:15 AM, the Administrator stated the care plan should include everything needed to take care of a Resident. He said if a resident uses smokeless tobacco that should be care planned.Record review of the facility's policy Care Plans, Comprehensive Person- Centered dated 03/2022 revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Record review of the facility's policy Resident Smoking dated 10/24/2022. Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking .Policy Explanation and Compliance Guidelines:5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.Record review of the facility's policy Comprehensive (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plans dated 10/24/2022. Policy: It is the policy of this facility to develop and implement a comprehensive person- centered care plan for each resident, consistent with resident rights, which includes measurable objectives and time frames to meet a resident's medical, nursing and psychosocial needs that are identified in the resident's comprehensive assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews, and record reviews the facility failed to ensure to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication rooms. The facility failed to ensure that the medications and/or biologicals stored in the medication room were not expired. This failure could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication and/or treatment. Findings included: An observation of the medication storage room on 06/16/2026 at 12:10 PM with the ADON reflected: One bottle of Aspirin 81 mg enteric coated tablets with an expiration date of 03/2026 Six bottles of Aspirin 325 mg tablets with an expiration date of 05/2026 Ten boxes of Bisacodyl 10 mg suppositories (a medication administered in the rectum to produce a bowel movement) with an expiration date of 02/2026. During an interview on 06/16/2026 at 12:45 PM, the ADON stated it was MR F's responsibility to check the medication storage room for expired medications. She stated she was unsure how often he checked the medication storage room. The ADON stated the policy of the facility was to dispose of expired medications on their expiration date. The ADON stated the consultant pharmacist monitored to ensure all expired medications were removed monthly. She stated if a resident were to have an expired medication administered to them then the medication may not be as potent and the resident may not receive the intended effect of the medication. During an interview on 06/16/2026 at 1:39 PM, the DON stated it was the ADON and MR F's responsibility to check the medication storage room for expired medications. She stated she was unsure of how often MR F checked the medication storage room for expired medications. The DON stated it was the policy of the facility to dispose of all expired medications properly. She stated both she and the consultant pharmacist monitored monthly by doing checks of the medication storage room. The DON stated if expired medications were administered to residents, then the medication may not be as effective, and the resident may not get the therapeutic benefit from the medication. During an interview on 06/16/2026 at 2:09 PM, MR F stated he had received training in the storage of medications when he was hired for the position in 2021. He stated he was responsible for checking for expired medications in the medication storage room. MR F stated he checked the medication room multiple times weekly for expired medications. He stated the expired medications that were observed in the medication storage room may have been overlooked. He stated the facility policy for medication storage was to dispose of expired medications appropriately. He stated if a resident were to receive expired medications, then the medication may be less effective. MR F stated the pharmacy consultant came in on an unknown frequency to monitor that he had removed all expired medications from the medication storage room. During an interview on 06/16/2026 at 2:14 PM, the ADM stated MR F was responsible for ensuring all medications placed in the medication storage room were not expired. He stated the charge nurses and nurse managers were responsible for checking the medication storage room weekly for expired medications. The ADM stated the nurse or medication aide was responsible for checking the expiration date on medications as they were pulled from the medication room and disposing of the medication if the medication was expired. He stated the pharmacy consultant was responsible for monitoring that all expired medications were removed from the medication storage room monthly. He stated the policy of the facility was to remove expired medications from the shelf and destroy the medication per policy. The ADM stated if an expired medication were administered to a resident, then depending on the medication, the effectiveness of the medication could be affected. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADM stated he was not sure why there were expired medications in the medication room, that it was a system failure. During an interview on 06/16/2026 at 2:37 PM, LVN H stated MR F, the nurses, and the medication aides were responsible for checking the medication room for expired medications when they remove anything from the medication storage room. She stated MR F checked the medication room for expired medications weekly. She stated she had seen the pharmacy consultant there about every 2 weeks, she thought, to monitor for expired medications. LVN H stated it was the policy of the facility to remove the expired medications from circulation and discard them per policy. She stated if expired medications were administered to the residents, then the effectiveness or stability of the medication could be affected. Review of facility policy titled Expiration Dating and Expired Medications, dated 10/01/2019, reflected: Policy: Drugs, which have been dispensed for individual residents, are not to be used beyond the expiration date indicated by the manufacturer, by the pharmacy, or based on the following criteria. The Facility is to strictly adhere to the expiration date. Procedure.7. If the expiration date is expressed in terms of month and year only, the medication will not be utilized after the last day of the month. 8. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the Facility. All expired medications will be disposed of per Facility policy. 9. A continuous monitoring system will be designated by the Director of Nursing to identify expired medications and remove them from the medication system.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infects for 1 of 2 residents (Resident #17) observed for infection prevention. The facility failed to ensure Enhanced Barrier Precautions were followed when TN E failed to wear a gown while providing wound care to Resident #17. This failure could place residents at risk for infection, hospitalization, and decreased quality of life. Findings included: Review of Resident #17's admission record, dated 06/16/2026, reflected a [AGE] year-old female was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Her diagnoses that included: paroxysmal atrial fibrillation (intermittent episodes of rapid, chaotic electrical activity in the heart), unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), and Peripheral vascular disease (a common condition characterized by narrowed arteries that reduce blood flow to the limbs, primarily the legs, leading to symptoms like leg pain and cramping). Review of Resident #17's Comprehensive MDS, dated [DATE], reflected a BIMS score of 11 which indicated moderate cognitive impairment. Section M - Skin Conditions reflected Resident #17 had 2 unstageable pressure ulcers (a pressure wound that has its wound base covered by dead tissue). Review of Resident #17's care plan, dated 03/25/2026, reflected under Problem Resident has the need for Enhanced Barrier Precautions due to: (wound) is at risk of infection, depression, feelings of isolation, and decline in physical activity with interventions that included .Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated. Review of Resident #17's Order Summary, dated 06/16/2026, reflected the following orders: Enhanced Barrier Precautions: Use gown and gloves for high contact resident care activities for those with known to be colonized [presence of microorganisms without causing disease or triggering an immune response] or infected with a CDC targeted MDRO as well as those with increased risk of MDR. (residents with wounds or indwelling medical devices) every shift with a start date of 03/25/2026. Wound Care: Right Heel/Stage IV Pressure Injury [a pressure ulcer involving full thickness tissue loss with exposed muscle, tendon, or bone]: Cleanse with WC/NS, pat dry. Apply Collagen [a wound care dressing used to promote healing by supporting tissue growth] to wound bed, cover with foam dressing. As needed for Stage IV Pressure Injury with a start date of 06/15/2026 Wound care: Right Heel/Stage IV Pressure Injury: Cleanse with WC/NS, pat dry. Apply Collagen to wound bed, cover with foam dressing. Every day shift every Mon, Tue, Wed, Thu, Fri for Stage IV Pressure Injury. During an observation on 06/15/2026 at 09:54 AM of wound care revealed TN E did conduct hand hygiene prior to putting on gloves and starting to provide wound care to Resident #17. There was a sign indicating Enhanced Barrier Precautions and there was a supply of personal protective equipment available hanging on Resident #17's door. TN E did not put on or wear a gown while performing wound are for Resident #17. Wound care was provided to Resident #17 according to her wound care orders. TN E did perform hand hygiene after she finished the wound care for Resident #17. During an interview on 06/15/2026 at 10:18 AM, TN E stated she had been trained on the enhanced barrier precautions and providing wound (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. TN E stated she forgot to put on the gown while providing care to Resident #17. She stated she was trained to wear a gown and gloves for residents with an open wound or indwelling medical device. TN E stated it was important to follow enhanced barrier precautions to protect the residents from any germs that might be on the staff's clothing. She stated by not wearing the gown she could have possibly spread infection to the resident. TN E stated the ADON and the ICP monitored to ensure enhanced barrier precautions were utilized when they did their rounds. During an interview on 06/16/2026 at 09:40 AM, the DON stated she had been trained in infection control and the use of enhanced barrier precautions. She stated the facility policy related to enhanced barrier precautions was to wear gown and gloves for any resident who has any kind of treatment, including wounds. She stated staff were expected to put on a gown and gloves prior to providing direct care. She stated if staff do not wear the gown and gloves as indicated in their policy, then bacteria could be passed on to the resident. The DON stated nursing management, primarily the ICP, monitored direct care staff for proper use of enhanced barrier precautions but she was unsure of how or how often. During an interview on 06/16/2026 at 11:14 AM, the ADM stated he had been trained in infection prevention and control and enhanced barrier precautions within the last quarter. He stated staff were expected to wear the required personal protective equipment, gown, and gloves, during direct care for any residents with the enhanced barrier precautions sign on their door. The ADM stated by not wearing a gown during direct care, the residents and/or the staff may not receive the sufficient amount of protection they required. He stated the ICP was responsible for monitoring the direct care staff and proper use of enhanced barrier precautions daily during rounds and also during weekly targeted rounds. During an interview on 06/16/2026 at 12:16 PM, the ICP stated she had received training on infection control procedures including enhanced barrier precautions. She stated enhanced barrier precautions was to protect residents from acquiring infections. She stated the policy indicated that staff providing care that required direct contact with the residents wear a gown, gloves, and, if indicated, a mask/goggles/face shield. She stated if gown and gloves were not worn, then staff were exposing themselves and the residents to possible infections and spreading of infection. She stated she was responsible for monitoring direct care staff utilize enhanced barrier precautions during random rounds. The ICP stated all staff received in-services about personal protective equipment quarterly and as needed if there is an identified concern. During an interview on 06/16/2026 at 01:50 PM, MA G stated she had received training related to enhanced barrier precautions. She stated she was trained to wear a gown and gloves when providing care to residents with the enhanced barrier precautions sign on their door. MA G stated staff were to wear a gown and gloves to prevent the spread of germs to the residents who were at a higher risk for infection. She stated the ICP was responsible for monitoring the proper use of personal protective equipment with enhanced barrier precautions when she did her rounds. During an interview on 06/16/2026 at 02:25 PM, LVN H stated she had received training related to enhanced barrier precautions and the personal protective equipment that was required to be worn during direct care with residents who have wounds or other medical devices. She stated all staff were responsible for wearing a gown and gloves when they provided direct care to the residents with the enhanced barrier precautions sign on their door. LVN H stated if a gown and gloves were not worn, then staff could bring whatever [germs] one residents had to another resident. She stated all staff were responsible for monitoring their coworkers throughout their rounds for proper use of personal protective equipment for residents that require enhanced barrier precautions. Review of facility policy titled Enhanced Barrier Precautions, dated 11/24/2025, reflected Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy Explanation and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance Guidelines: .2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for residents with any of the following:i. Wounds (e.g., chronic wounds such as pressure ulcers, .) even if the resident is not known to be infected or colonized with a MDRO.3. Implementation of Enhanced Barrier Precautions:a. Make gowns and gloves available near or outside of the resident's room.4. High-contact resident care activities include: .h. Wound care: any skin opening requiring a dressing.		